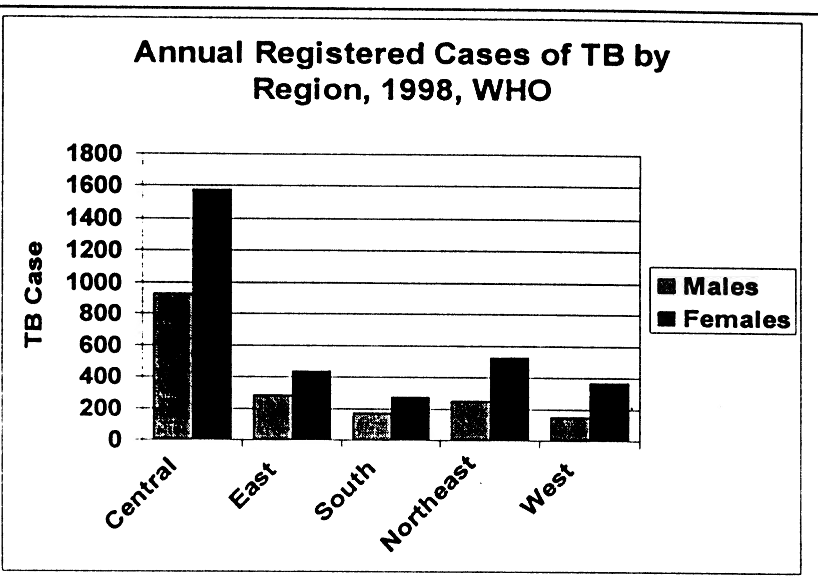


Prevalence of active TB = 133,000
Incidence of TB = 70,000/ year
Mortality due to TB = 15,000/year

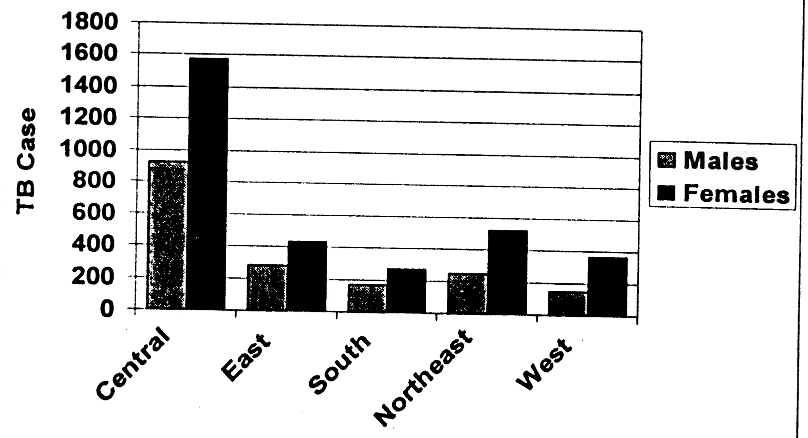
Third Priority: Control of Communicable Diseases

Infectious diseases account form more than half of all premature deaths and disability. Pneumonia kills the elderly as well as children and tuberculosis is a major killer of young adults. An estimated 15,000 die of tuberculosis each year in Afghanistan while another 70,000 are newly infected. The prevalence of active TB cases in 1999 is considered to be about 133,000 in Afghanistan, more than three-fourths are young adults and around 70% are women. Directly Observed Treatment, Short-course (DOTS) can prevent 80% of all tuberculosis deaths, but current resources can only provide the recommended DOTS treatment for 8400, a mere 6.3% !

While about 300,000 cases of malaria are reported each year in Afghanistan,with only about one-tenth reported, the total is estimated to be near 3,000,000 (thirty times the level in 1978). In addition, the most dangerous form of malaria in the region, falciparum, has shot up from 1% of the cases then to more than 5% now. Bednets and other prevention and treatment strategies can prevent 50% of all malaria deaths.

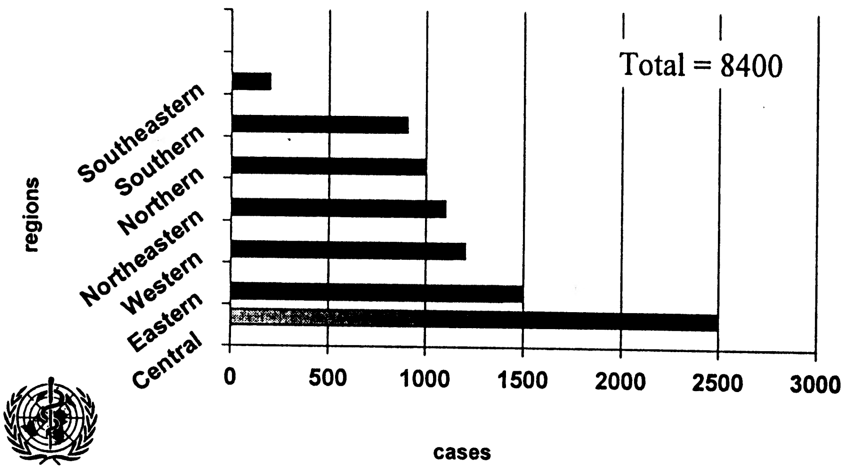
More than 270,000 people in Afghanistan have active leishmaniasis, another insect-borne parasitic disease, up from 14,000 three years ago. The disease often scars the face and may mutilate the nose and mouth. People disfigured by this disease may be rejected by their families, adding to their misery. Wide distribution of bednets and early treatment of the lesions are imperative to stop the spread of the disease.

Annual Registered Cases of TB by Region, 1998, WHO

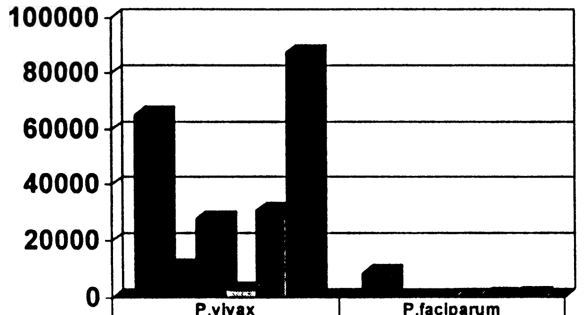


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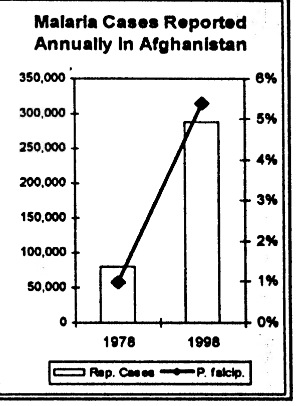
Number of TB patients scheduled for DOTS treatment with WHO and NGO assistance in 1999



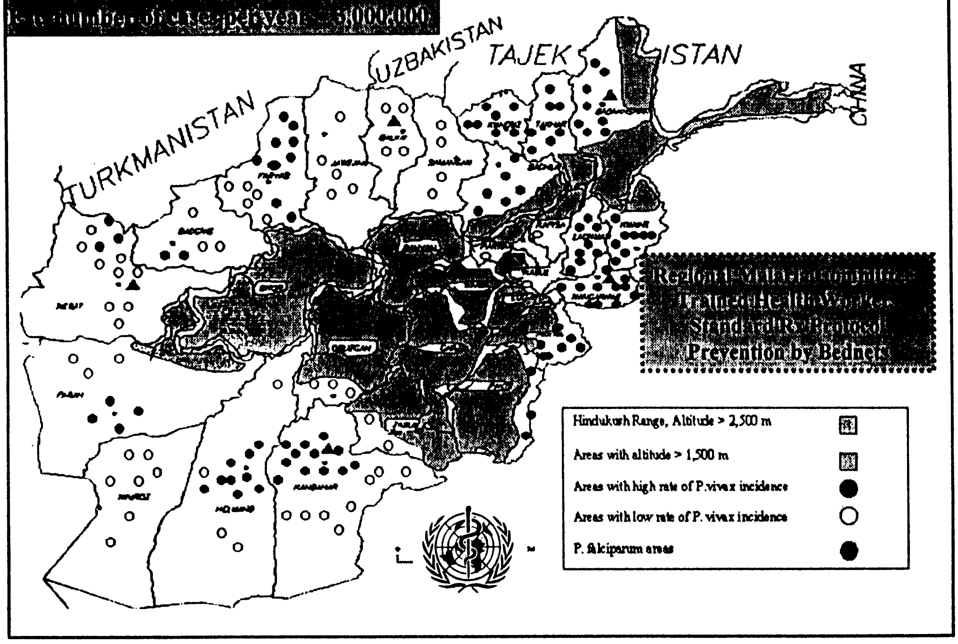
Annual Reported Cases Malaria, 1998

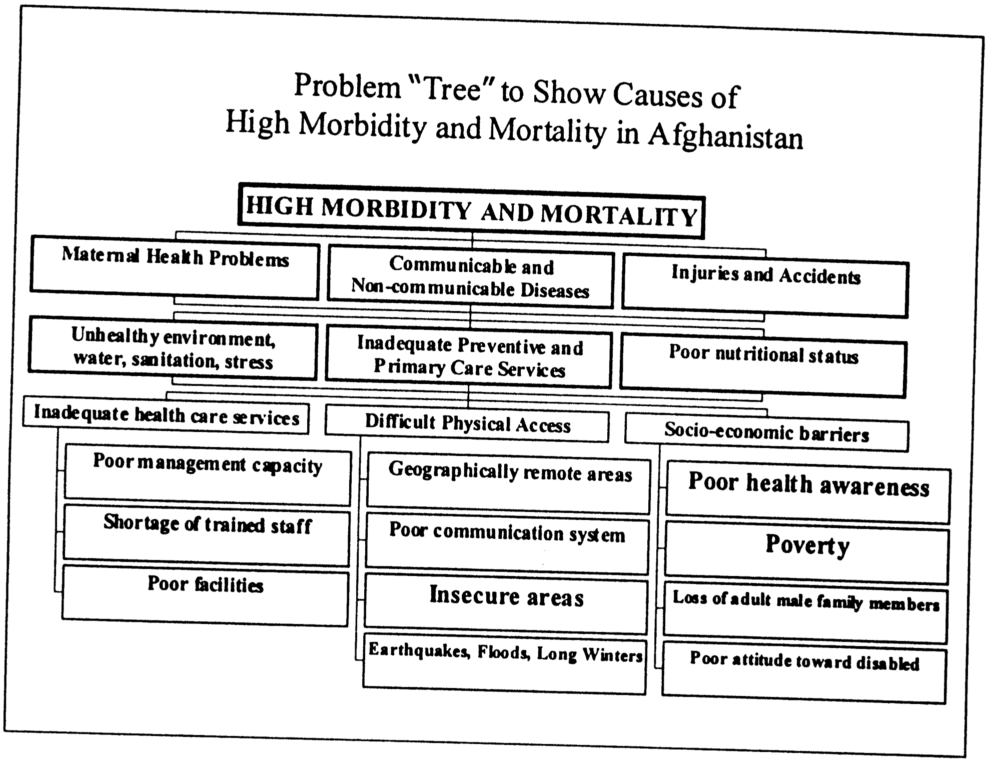


	P.vivax	P.faciparum
■ Eastern	65100	8512
■ Central	10426	121
■ Western	27562	47
■ Southern	2442	198
■ S.eastern	30954	631
■ N.eastern	87479	931



Distribution of Malaria in Afghanistan





The cause of infectious diseases is typically ascribed to the microbes in the environment or other immediate causes such as lack of safe drinking water and sanitary surroundings. On another level, however, the root cause of excess morbidity and mortality in Afghanistan can be considered to be the lack of access to primary care and prevention services, including immunization programs and reproductive health services.

Progress has been made in moving away from a centralized vertical health care system emphasizing curative medicine toward a regionalized integrated system emphasizing preventive and primary health care approach. However, most regions do not have even one physician per 10,000 population nor even one hospital bed or trained birth attendant per 1,000 population.

Lack of access can be further refined as a problem of insufficient training programs and poor distribution of available services exacerbated by inadequate supervision, monitoring, incentives, motivation, and security to keep the trained persons in place. Lack of access certainly includes physical access to those services: poor roads due to destruction and geography, destroyed communication systems, destroyed and lacking health-related facilities, lack of resources, drugs, supplies, and insecure areas as physical barriers.

Poor utilization of health services may be due to lack of popular health knowledge required to take initiative to seek care and the ability to access that information through schools, media, or mosques. Socio-economic factors such as poverty and low social status of women can also be barriers to utilizing health services. For vulnerable populations, poor utilization may be due to their lack of recognition or insufficient effort to inform them or become informed of their needs.

MANAGEMENT AND COORDINATION MECHANISMS TO MAKE A REALITY OF DECENTRALISED HEALTH CARE -1999

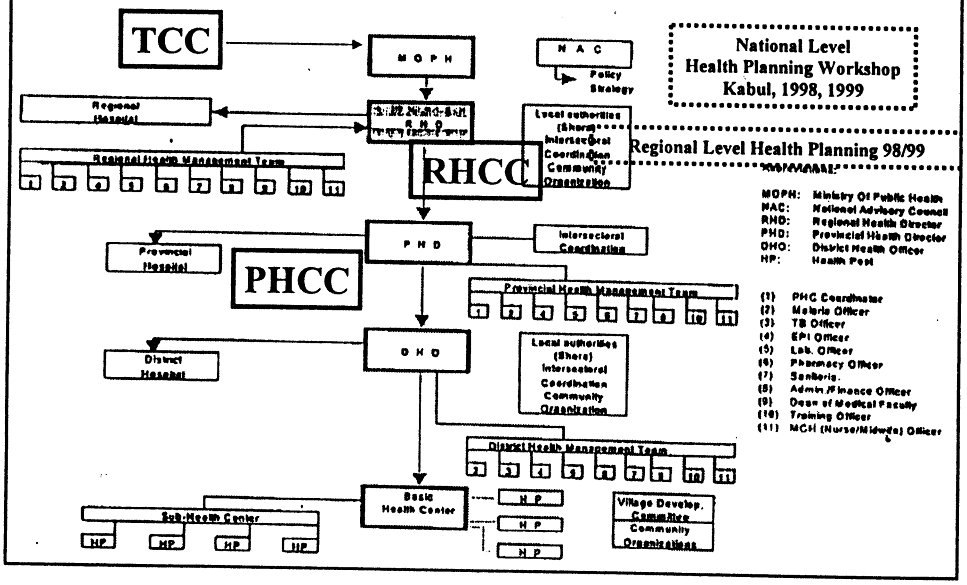
NATIONAL LEVEL

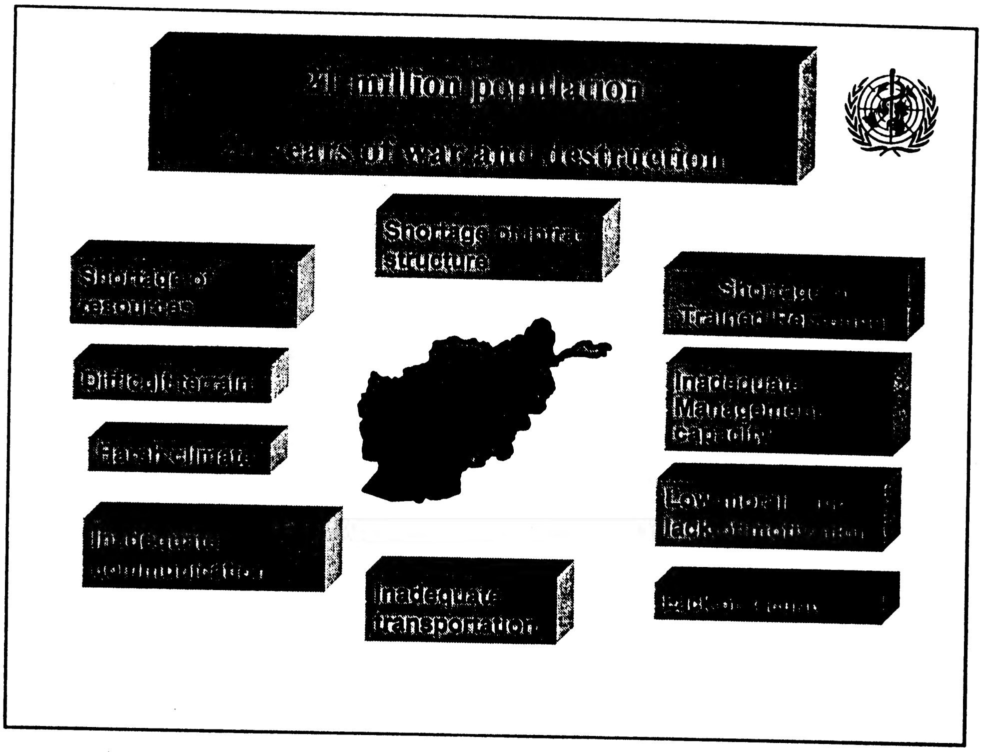
- Technical Coordination Committee (TCC)
- NGO Coordinating Bodies - Health Sub-Committees

REGIONAL LEVEL

- Regional Health Management Teams
- Regional and Provincial EPI Management Teams
- Regional and Provincial Health Coordination Committees (Sectoral committees of RCBs)
  - MCH Coordination Committees
  - NIDs Task Forces
  - Cholera Task Forces
  - Water /Sanitation Management Committees

Organizational Chart of Regional Public Health Directorate (1994)





Issues and Problems

1. Access & Logistics
2. Utilization & Attitudes
3. Quality
4. Sustainability

Issues and Problems
1. Access

- Insufficient number of health facilities
- Maldistribution of health facilities
- Inefficient strategies
- Unavailability of service in conflict areas
- Mobile and displaced populations

Issues and Problems
& Logistics

- Shortages in drugs and supplies
- Geographically remote areas
- Insecure areas
- Expensive transport costs

Issues and Problems
2. Utilization

LACK OF PUBLIC AWARENESS about:

- Importance of antenatal services, immunization and early treatment
- Availability of antenatal services, immunization and early treatment

Issues and Problems
& Attitudes

- False concepts of disease
- Conflicting family priorities (gender perspective)
- Poor interpersonal communication at health facility

Issues and Problems
3. Quality

- Staff poorly trained or inexperienced
- Missed opportunities
- Lack of follow-up
- Over crowded facilities

Issues and Problems
4. Sustainability

- Lack of health sector resources
- Lack of community resources
- Huge needs

Solutions
1. Support

- Commitment to PHC approach by authorities, UN agencies, NGOs
- Coordination and coherent program policies and strategies
- Joint planning
- Support to existing facilities
- Expansion to needy areas

Solutions
& Logistics

- Proper estimation of requirements
- Timely provision of requirements
- Fund raising

Solutions
2. Information

- Public, Media and Medical Personnel:
- Benefits of antenatal care, immunization, early treatment.
- Value for the whole family.

Solutions
3. Training

- Refresher training for existing hws
- Support to educational system for training of new hws (primary and up)
- Especially training of female hws in medical teaching institutions

Solutions
& Supervision

Monitoring for early detection

of problems facing the programme

and proper action

Solutions
4. Sustainability

- Raising consumer awareness
- Afghanization
- Involvement of private sector
- Cost sharing

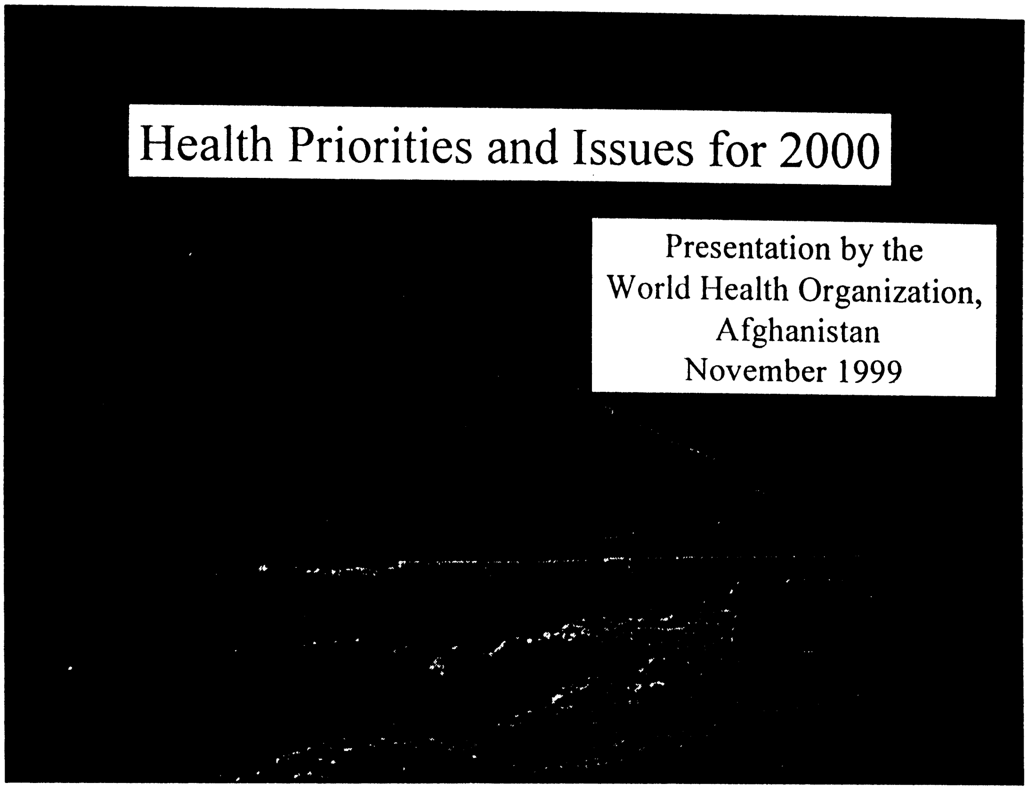
Solutions

1. **Support & Logistics**
2. **Information**
3. **Training & Supervision**
4. **Sustainability**

A well-tested solution to most health problems is a strongly integrated primary health care (PHC) system throughout the country. Most diseases can be prevented or treated at an early stage through activities such as antenatal care, immunization, and health education at the Basic Health Centers (BHCs), which are also the mainstays of the tuberculosis and malaria control programs. For problems arising during childbirth and for infants, who may become ill and die within 24 hours, there is no substitute for equipped, well-trained and available PHC workers.

Coordination among authorities, aid agencies, organizations, and the community improves the effectiveness of health service development. Through coordinated approach, all health providers, according to their level of expertise, should recommend the same protocol for maternal care, childhood immunization, control of diarrheal diseases, ARI, malaria and tuberculosis. Also the disease surveillance system depends on the reporting of health care providers to the regional center so that epidemics can be averted and essential supplies assured. To achieve this coordination, great efforts are needed to upgrade the managerial skills of regional, provincial, and district health officers in the coordinating body and to focus on the development of health services in close partnership with local community organizations.

The priority Appeal strategies are to improve access, quality and utilization of health services through support of existing clinics, expansion to needy areas, training and refresher courses for health workers, and improving health education, surveillance and management systems. Proper implementation of these strategies could reduce mortality rates by half in less than a decade. It's a challenge that needs our support.



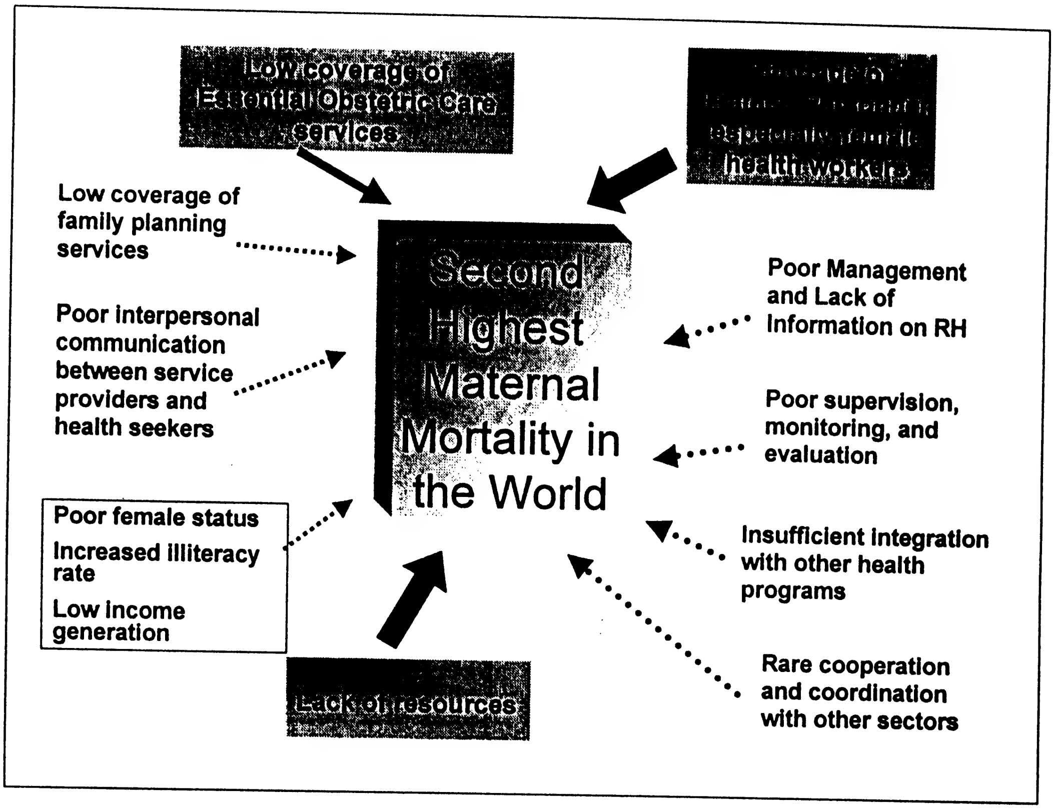
Afghanistan Health Priorities and Issues for 2000

WHO Afghanistan Presentation to the APB, November 1999

WHO's goal is to foster the attainment by all peoples
-- especially the poor and most vulnerable --
of the highest possible standards of health.

The guiding principles of WHO are: 1. "We can't do it alone,
so we work in partnership with others."
2. "We can't do it all at once so we set priorities." [1]
Priority setting helps focus the world's attention, resources
and actions on innovative and cost-effective
public health action with specific goals and measurable results.

[1]**Dr. Gro Harlem Brundtland, Director-General, World Health Organization, as quoted in "Removing Obstacles to Healthy Development," WHO, 1999**



First Priority: Safe Motherhood

"It is estimated that every day in Afghanistan about 45 women die of pregnancy related causes resulting in over 16,000 maternal deaths each year." The critical goal of Safe Motherhood is to ensure that all pregnant women have access to good quality maternal health services that can detect and manage life threatening complications.

Only about 15% of deliveries in Afghanistan are attended by trained health workers, most of whom are Traditional Birth Attendants (TBAs) and greater than 90% of births take place at home. In 2000, the goal is to integrate the TBAs into the health system by providing linkages that include proper supervision and referral mechanisms for complicated cases. Every clinic should supervise TBAs and assist with referrals.

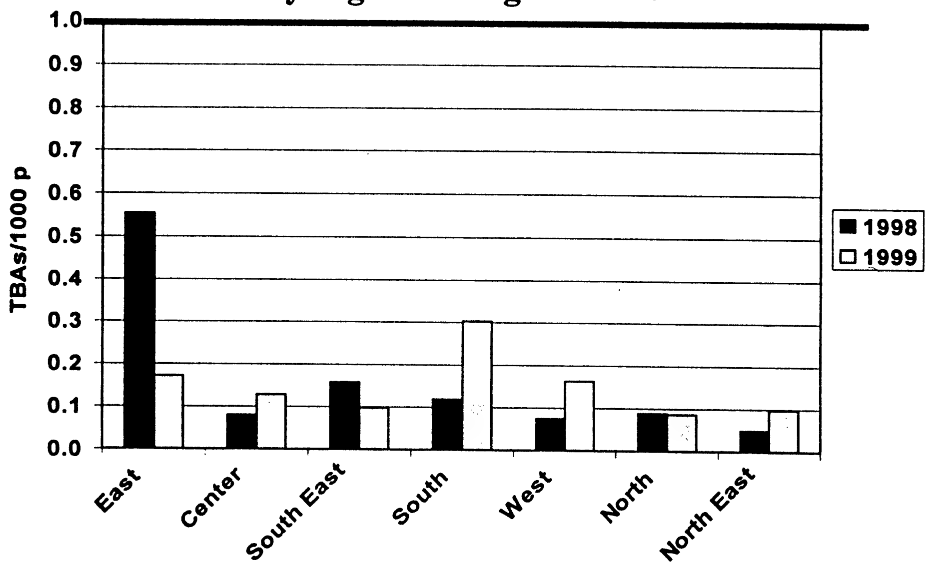
Emphasis will be placed on training and deploying an adequate number of professional skilled midwives to eventually provide the majority of delivery care. MOPH is opening schools, offering a three year training course for female nurses/midwives, in Herat, Mazar, and Jalalabad.

The minimum acceptable level of Essential Obstetric Care Services (EOC) for every 500,000 people is one comprehensive EOC facility which can perform surgery and provide blood transfusions in addition to four basic EOC facilities which have the capacity to administer intravenous medications and assist vaginal deliveries. Afghanistan has less than one-fourth of this minimum level of EOC service facilities and they are unevenly distributed, functioning mostly in the Eastern and Central Regions. Existing hospitals are always short of funds!

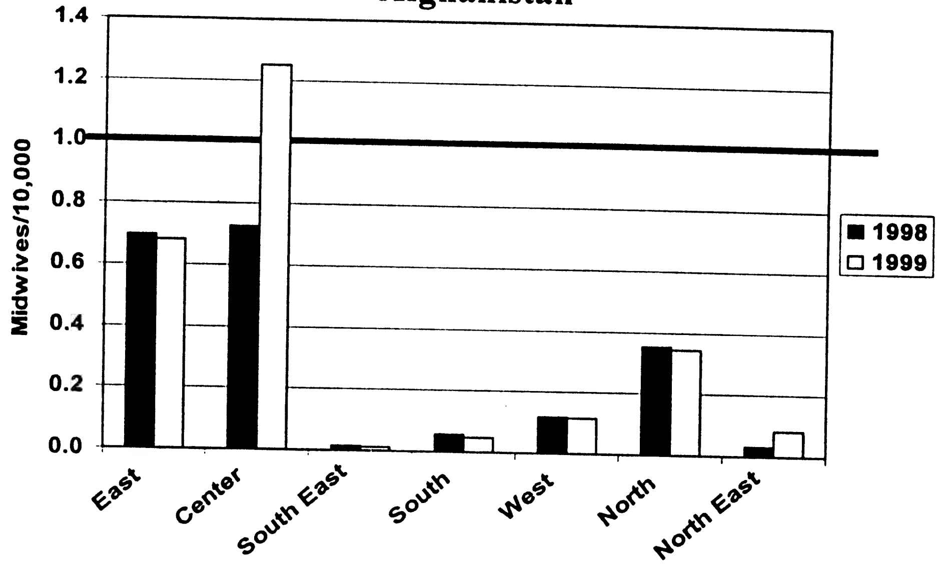
High Maternal Mortality Rates

- 1st highest MMR: Sierra Leone (1,800/100,000 Live Births)
- 2nd highest MMR: Afghanistan (1,700/100,000 Live Births)
- 3rd highest MMR: Somalia (1,600/100,000 Live Births)

Comparison between the 1998 and 1999 reported no. of TBAs per 1,000 population by region in Afghanistan

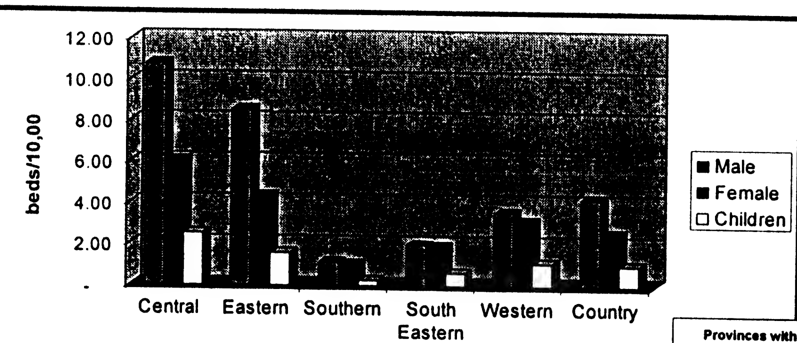


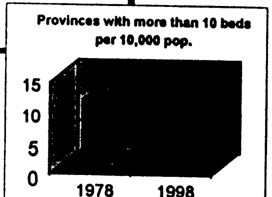
Comparison between the 1998 and 1999 reported no. of midwives per 10,000 population by region in Afghanistan



Hospital Beds (per 10,000 pop.) by gender and by region in Afghanistan, 1998

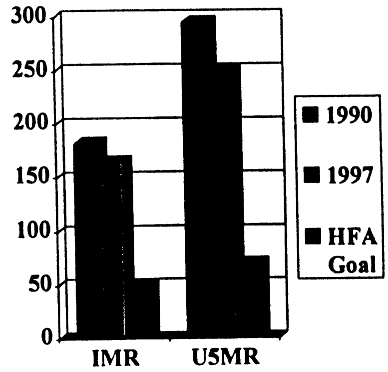
Health Planning Workshop, Kabul, February 1998





Afghan Infant Mortality Rate and Mortality Rate of Children Under Age 5 Years

- **Infant Mortality Rate:**
  - 1990 182 per 1000 live births
  - 1997 165 per 1000 live births
  - Goal 50 per 1000 live births
- **Under 5 Mortality Rate:**
  - 1990 295 per 1000 live births
  - 1997 250 per 1000 live births
  - Goal 70 per 1000 live births
- **Chief causes of childhood mortality are: perinatal causes, pneumonia, diarrhea, malnutrition and vaccine preventable diseases.**



"Safe Motherhood" contributes significantly to Child Health by minimizing the perinatal causes of infant mortality, including birth trauma and neonatal tetanus, contributing about 20% of the mortality rate.

An estimated 20% of childhood deaths are due to each of three infectious causes: pneumonia, diarrhea, and vaccine preventable diseases (measles, pertussis, diphtheria, tetanus and polio). Malnutrition and lack of basic health services and essential drugs raise the death rate from these diseases even higher.

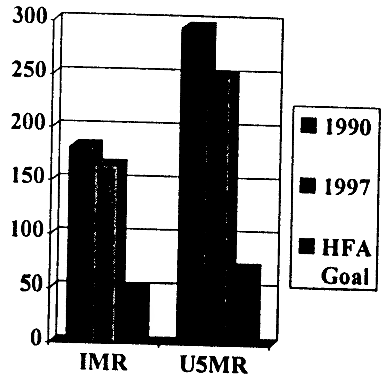
Second Priority: Expanded Program of Immunization (EPI)

Polio Eradication, the goal for the end of the year 2000, will rid Afghanistan of a crippling disease responsible for half of all limb disabilities. The other half are due to land mines and war injuries. To reach the goal, routine EPI needs to be improved, more rounds of supplementary immunization (NIDs) are needed next year and then ongoing surveillance for polio cases for about three more years. So far this year, 75 new polio cases have been identified. We hope there will be none in 2001.

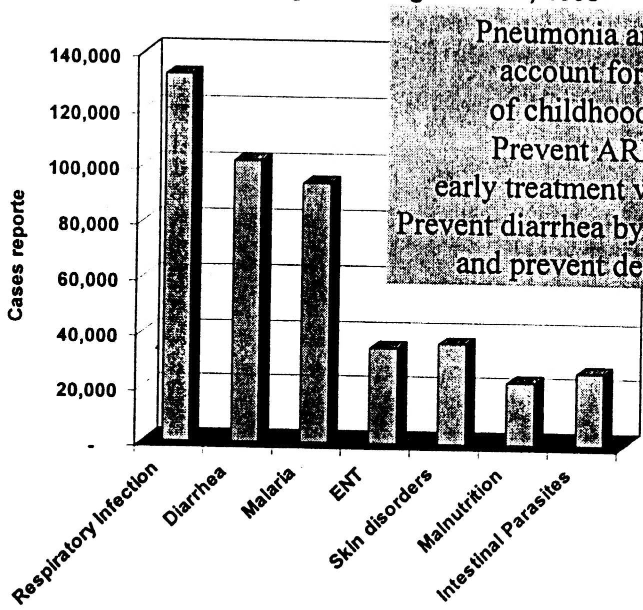
As well as creating a polio-free world, polio eradication activities are strengthening our capacity to tackle other preventable diseases. Measles Elimination, the goal for 2010, requires high routine EPI coverage. Current coverage of 288 out of 330 districts by 426 fixed centers needs to be improved, both by increasing the number of fixed centers (clinics offering EPI services) and by improving the consistency and quality of services andoutreach activities of existing centers.

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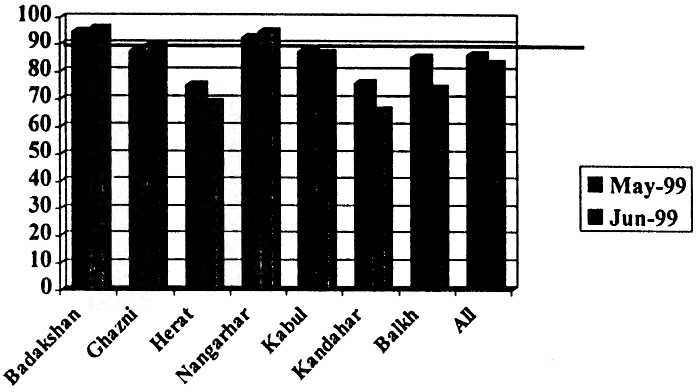


Top seven health problems at BHCs in Eastern and Western Region of Afghanistan, 1998

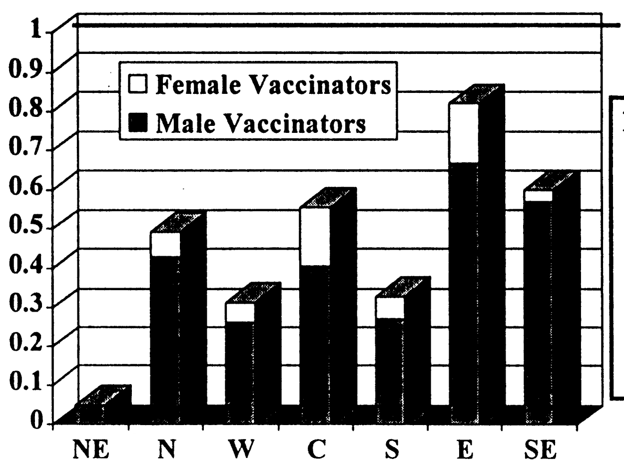


Pneumonia and Diarrhea account for over half of childhood mortality. Prevent ARI deaths by early treatment with antibiotics. Prevent diarrhea by safe water suppl and prevent deaths by ORT.

NIDs COVERAGE AMONG CHILDREN <5 years BY AREA, 1999 Coverage Survey



Male and Female Vaccinators per 10,000 population by Region in Afghanistan, 1999, UNICEF



Immunization centers: 426

Service providers: 900 (150 female)

Districts with F.C.: 288/330

Measles Outbreaks - Afghanistan

- Nov 1998 -Kandahar
- Dec 1998 -Balkh - 270 reported deaths
- Jan 99 - Saripul
- Feb 99 - Paktika- 18 reported deaths
- Feb 99 - also Ghazni and Khost
- March 99 - Uruzgan
- April 99 - Baghlan -132 reported deaths

